February 25, 2011

Medicaid Reforms
c/o Dr. Barbara Langner, Medicaid Director
Kansas Health Policy Authority
900 SW Jackson, Suite 900
Topeka, Ks. 66612

Re: Kansas Independent Pharmacy Service Corporation (KPSC)

Response to Request for Ideas re: Medicaid Cost Savings and Reform

KPSC has a long history of working with staff of the Department of Social and Rehabilitation Services (SRS) and the Kansas Health Policy Authority (KHPA) on cost savings, plan design and policy as it relates to the fee-for–service Medicaid pharmacy program. KPSC CEO Peter Stern and Ron Gaches, who represents KPSC in state legislative/agency related matters, recently met with Lt. Governor Dr. Jeff Colyer and discussed this current solicitation of ideas. We appreciate the opportunity to provide information to Lt. Governor Colyer and KHPA for consideration.

We are providing brief descriptions of a number of areas of focus for your review as well as some other specific comments. We can discuss any of them in more detail with KHPA staff and others.

Implementing a Preferred Drug List for Antidepressants – $22 million was spent in 2010 by the state of Kansas for mental health drugs, including those used to treat depression and schizophrenia. This represents a significant percentage of the $52 million that Kansas spent in 2010 as its share of fee-for-service prescription drug costs. There has been deep concern expressed by persons representing the mental health provider community in possibly having more active management of these drug categories, such as establishing preferred drug lists for them. However, a majority of other state Medicaid programs have placed mental health into their preferred drug list process. We encourage the state to look closely at moving antidepressants and possibly drugs used to treat ADHD into the preferred drug list process.

Beneficiary Copayment Structure – We understand that there has been some interest by legislators and other policy makers in establishing a tiered copayment structure that may help influence beneficiaries to use lower cost drugs. It has been our understanding that CMS has fairly strict limitations on copayment levels. We believe that raising the upper limit on copay levels can influence beneficiary behavior leading to increased use of generic and preferred brand drugs. The generic dispensing rate for fee-for-service Medicaid beneficiaries in 2010 was 68%, while the full substitution rate possible nationally is now up to 80%. We encourage and support action to broaden copayment ranges.

Expansion of step therapy – The state presently has limitations on the step therapy process that are commonly found in the commercial prescription benefit market. A full step therapy program would allow a graduated step process where a lesser cost therapeutic alternative is allowed. The state will benefit in expanding use of certain generics and possibly certain OTCs, by having state law changed to allow broader substitutions of therapy alternatives for highly utilized drug categories.

(Note – any method used to increase generic use can provide significant cost savings. According to a secondary source, in 2008, the average cost of a generic for Kansas Medicaid beneficiaries was $28.46 compared to an average of $251.96 on brand name drugs).

Provide medication therapy management (MTM) services to specified beneficiaries utilizing multiple therapies – *one of the most important ways to contain Medicaid expenditures in the **longer term** is to change or enhance the manner in which services are coordinated and managed, especially for those beneficiaries that are seen as high-cost or high risk or who have multiple disease states.* MTM has expanded greatly in the past ten years and has been used very effectively in the public and private sectors of the pharmacy benefit market. KPSC has contacted *Outcomes Pharmaceutical Health Care*, knowing their track record for managing MTM programs in a wide range of settings, their documented cost savings (e.g., product cost savings, unnecessary therapy, patient education, medication review/reconciliation, cost avoidance), and their documented successes/return on investment. Their well developed software is easy for pharmacist provider use. We strongly encourage KHPA/Medicaid to schedule a visit with Outcomes to review their program. Information on their programs can also be accessed at www.getoutcomes.com.

Current and Upcoming KHPA Plan Design Modifications -We support actions being taken by KHPA this year to reduce costs including implementing a 4 brand limit per month (from 5) and reduction of over the counter coverage.

Concern re: Comments by HHS Secretary Sebelius - HHS Secretary Kathleen Sebelius has written governors recently outlining some general ideas on potential Medicaid program options. In the letter, Sec. Sebelius suggests the possible application of mail order to Medicaid. We disagree with the assumption that mail order can provide cost savings for this population. First, retail pharmacies have an ongoing track of dispensing a much larger percentage of generics than mail order providers (which are commonly owned by large prescription benefit management companies or PBMs). Retail pharmacies had a 69% generic dispensing rate in 2009. The largest PBMs, which have a dominant presence in the U. S. market, had generic dispensing rates of less than 60%. Also, various segments of the Medicaid population are fairly transient, leading to waste of mailed medication. This waste factor is compounded when considering that mail order pharmacies commonly dispense for 90 day supplies.

Comment On Pharmacy Reimbursement - We wish to provide a comment on pharmacy fees for your consideration. Aside from the dispensing fee cuts in the fee-for-service Medicaid pharmacy program that were implemented in January 2010 but removed in July 2010, pharmacies have had additional reimbursement reductions in the past two years. A change in AWP pricing methodology, which resulted from federal court decision (in which pharmacies were not a party but were impacted directly and negatively) led to an immediate 4% reduction in reimbursement in September, 2009. Also, the state Medicaid program enacted adjustments to maximum allowable cost (MAC) pricing on numerous generics in the fee-for service program in the summer of 2009. The Medicaid fee-for-service prescription drug program expenditures in FY 2010 were approximately $166 million, *down* about 5.5% from FY 2009. It is our understanding that much of this cost savings is due to the fee reductions from the AWP and MAC adjustments. We are also concerned about the pending application of average manufacturer pricing (AMP) to generics. While there is uncertainty about the timing of the application of AMP to Medicaid generics, its eventual use could further reduce pharmacy reimbursement. Due to the above reimbursement reductions already implemented and with AMP and other pricing methodology changes being planned or considered by CMS, we respectively ask that no other pharmacy reimbursement reductions be considered at this time.

We thank you again for the opportunity to provide this information and welcome any questions the staff of KHPA or other may have.

For questions, please contact -

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